DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 8/17/13

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445108	A. BUILDING _____ B. WING _____	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint invosligation number 31798, conducted in conjunction with the annual survey, on July 1-3, 2013, at NHC Healthcare, Murfreesboro, no deficiencies were cited in relation to the complaint under 42 CFR Part 482.13 Requirements for Long Term Care.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a call light within reach for one (#99) of thirty-nine residents reviewed. The findings included: Observation on July 1, 2013, at 2:37 p.m., revealed resident #99 on the bed with bilateral quarter side rails in the up position at the head of the bed. Further observation revealed the call light was on the chair next to the head of the bed and was not within reach of the resident. Interview on July 1, 2013, at 2:40 p.m., in the resident's room, with Certified Nurse Aide #2 revealed the resident was capable of activating the call light. Further interview confirmed the call	F 246	F246 Overseen by the DON resident #99's call light was verified to be in place. On 07/01/13. Overseen by the DON : on 7/1/2013, all patients in Health Care Center were monitored and call lights were visualized and were within reach. Overseen by the DON; in-service training began for all licensed nurses and CNA's on 7/1/2013 regarding their role in assuring that patient's call lights are always placed within reach. Beginning 7/2/2013, a quality assurance study will be overseen by the DON in which 20 random residents will be monitored randomly throughout days/nights to verify placement of call lights for 4 weeks.. The DON will monitor compliance of this study, address results as indicated and report to the center's Quality Assurance committee which consists of the Administrator, Director of Nursing, Medical Director, Social Worker, Health Information Manager, Director of Dietary and Nurses Managers. The study will continue as directed by the Quality Assurance Committee.	7/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Foster
TITLE: Administrator
(X6) DATE: 7/17/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 light was not within the reach of the resident.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to update the care plan for one resident (#79) of thirty-nine residents reviewed. The findings included: Resident #79 was admitted to the facility on November 3, 2006, with diagnoses including End Stage Renal Disease, Diabetes, Hypertension,	F 279	F 279 Overseen by the DON the care plan for patient #79 was updated regarding care for their dialysis site on 07/02/13. Overseen by the DON; on 7/2/2013, all residents with dialysis/shunts care plans were reviewed and updated accordingly. Dialysis care plan was updated to reflect care for dialysis access site. Overseen by the DON; in-service training began for all licensed nurses on 7/3/2013 regarding dialysis patient's plan of care and the appropriate care of access site. Beginning on 7/3/2013, a quality assurance study will be overseen by DON in which 100% of dialysis patient's records will be reviewed initially to reveal if plan of care reflects appropriate access site care weekly for 4 weeks. The DON will monitor compliance of this study, address results as indicated and report to the center's Quality Assurance committee which consists of the Administrator, Director of Nursing, Medical Director, Social Worker, Health Information Manager, Director of Dietary and Nurses Managers. The study will continue as directed by the Quality Assurance Committee.	7/20/13

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F 279	Continued From page 2 Atrial Fibrillation, and Peripheral vascular Disease. Medical record review revealed the resident had a dialysis access in the right upper arm and received dialysis three days a week at an outpatient clinic. Medical record review of the care plan updated March 31, 2013, revealed the dialysis acess was not care planned to address the care of dialysis access located in the right upper arm. Further review revealed the care plan did not address the practice which requires no needle sticks or blood pressure checks in the arm of the access. Observation and interview on July 2, 2013, at 12:30 pm, revealed the resident was sitting in the recliner in the room, with a gauze bandage on the right upper arm. Resident stated had just got back from dialysis. Interview with Registered Nurse Supervisor #1, on July 2, 2013, at 2:30 p.m., at the nurses' station, confirmed the care plan did not address the care of the resident's dialysis access in the right upper arm.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		

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F 315	Continued From page 3 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assess a resident's bladder status and implement a bladder training program to maintain/improve bladder function for one (#86) of thirty-nine residents reviewed. The findings included: Resident #86 was admitted to the facility on January 9, 2013, with diagnoses including Falls, Hypertension, Gastroesophageal Reflux Disease, Diverticulosis, Dementia, Depression, Anxiety, Atherosclerotic Cardiovascular Disease. Review of nursing care plan dated January 9, 2013, revealed bladder incontinence was not addressed as a problem in itself but was noted as an intervention for altered skin integrity - to keep dry and do pericare after incontinence. Review of the Occupational Therapy (OT) consult dated January 10, 2013, revealed "...review of this patient's chart does not reveal a condition that would require intervention by an OT..." Continued review of the consult revealed "...intervention would not produce any significant changes until the underlying medical condition is addressed..." Review of the Urinary Incontinence and Indwelling Catheter assessment from the 5 day	F 315	F315 Resident # 86 had been previously discharged from the center. Overseen by the DON all patient care plans were reviewed to assure there was a bowel/ bladder assessment performed within 72 hours of admission and filed in the care plan tab in the chart. This was completed 07/03/13 Beginning 07/03/13, Overseen by the DON, the Bowel/Bladder Assessment Form was updated and revised and In-service training began for all Licensed Nursing Staff to ensure they are aware that this particular assessment is due within 72 hours of admission. Overseen by the DON, beginning the week of 7/8/2013; a random audit of 10 newly admitted residents—records will be reviewed to assure the bowel/bladder assessments are being performed within 72 hours of admission and place beneath the appropriate care plan tab in chart weekly for 4 weeks. The DON will monitor compliance ofthis study, address results as indicated and report to the center's Quality Assurance committee which consists of the Administrator, Director of Nursing, Medical Director, Social Worker, Health Information Manager, Director of Dietary and Nurses Managers. The study will continue as directed by the Quality Assurance Committee.	7/20/13

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F 315	Continued From page 4 Minimum Data Set, dated January 16, 2013, revealed modifiable factors contributing to transient urinary incontinence were pain and medications. Continued review of the form revealed sections on other factors contributing to incontinence, laboratory tests, diseases and conditions, type of incontinence were not completed. Further review of the form revealed a section on analysis of findings: review indicators and supporting documentation, and draw conclusions, description of problem, causes and contributing factors, and risk factors related to care area revealed documentation including PT/OT (Physical Therapy/Occupational Therapy) notes, MAR (Medication Administration Record), risks. Further review of the form revealed a section entitled referral to another discipline with PT/OT to increase independence written under the statement. Continued review of the form revealed a section entitled document reason(s) care plan will/will not be developed and documentation included "...@ (at) risk for unwanted SE (side effects) of meds, UTI (urinary tract infection), ADL (activities of daily living) deficit, and falls..." Further review of the form revealed no documentation as to whether a care plan would or would not be developed. Interview with the Director of Nursing (DON) on July 2, 2013, at 4:10 p.m., in the conference room, confirmed a bladder training program had not been developed for this resident. Continued interview with the DON on July 3, 2013, at 7:53 a.m., in the conference room, confirmed the resident did not have a 72 hour bladder assessment/voiding pattern completed. Further interview with the DON confirmed the only bladder assessment available was the 5 day MDS	F 315		

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F 315	Continued From page 5 (Minimum Data Set). Continued interview with the DON confirmed the care plan did not address improving bladder function and/or restoring as much normal bladder function as possible.	F 315		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F 431 Overseen by the DON, the IV bag for resident #99 was removed and discarded on 7/1/13. Overseen by the DON, all other patient IV sets currently hung were checked for appropriate labeling on 7/1/13. Overseen by DON; on 7/1/2013 in-service training began with all licensed nurses regarding IV Therapy Policy/ Guidelines. CNA's also in-service on visualization of IV bags and assuring they are labeled appropriately. Beginning 7/1/2013, a quality assurance study will be overseen by DON in which up to 5 random patients with IV's will be selected for monitoring of proper labeling per IV Therapy Policy/Guidelines, weekly for 4 weeks. The DON will monitor compliance of this study, address results as indicated and report to the center's Quality Assurance committee which consists of the Administrator, Director of Nursing, Medical Director, Social Worker, Health Information Manager, Director of Dietary and Nurse Managers. The study will continue as directed by the Quality Assurance Committee.	7/20/13

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F 431	Continued From page 6	F 431		

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, interview, and facility policy review, the facility failed to label an intravenous (IV) bag for one (#99) of thirty-nine residents reviewed.

The findings included:

Resident # 99 was admitted to the facility on February 26, 2013, with diagnoses including Congestive Heart Failure, Hypertension, Diabetes with Renal Manifestations, Stage III Chronic Kidney Disease, Morbid Obesity, Depression, Anxiety, and Chronic Respiratory Failure.

Review of the physician phone order dated June 27, 2013, revealed "...3) Ertepenem (antibiotic medication) 1 gm (gram) IV Q day x (Intravenously every day for) 7 days... UTI (Urinary Tract Infection)..."

Observation on July 1, 2013, at 2:37 p.m., in the resident's room, revealed an IV medication bag on an IV pole with the pharmacy label dated June 29, 2013, of "...INVANZ (antibiotic Ertepenem) 1gm (gram)...100 ml (milliliters) infuse contents of bag 1gm over 60 min (minutes) every day for 7 days...". Further observation revealed no facility label addressing the date and time of the administration, and no initials of the nurse administering the medication.

Interview on July 1, 2013, at approximately 2:45 p.m., with Licensed Practical Nurse #2 and

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F 431	Continued From page 7 Licensed Practical Nurse #4 in the resident's room, confirmed the IV bag failed to have the administration date, time and initials of the nurse. Review of the facility policy entitled "IV Therapy" revealed "...IV solutions are to be changed and labeled every 24 hours..." Interview with the Director of Nursing, in the conference room, on July 2, 2013, at 1:50 p.m., confirmed the IV bag was to be labeled with the administration date, time and nurse's initials.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 Overseen by Director of Housekeeping, on 7/1/2013, patient #8's fan was cleaned accordingly. Overseen by Director of Housekeeping on 7/1/2013, all of fans which were currently in use were monitored for debris and cleaned accordingly Overseen by the Director of Housekeeping and DON; in-service teaching began for all licensed nursing, CNA's and housekeeping staff to be vigilant to cleanliness of fans including fan guards and fan blades. Beginning 7/3/2013, a quality assurance study will be overseen by DON and Director of Housekeeping in which up to 10 random patient fans will be monitored and inspected for debris monthly for 3 months. The DON will monitor compliance of this study, address results as indicated and report to the center's Quality Assurance committee which consists of the Administrator, Director of Nursing, Medical Director, Social Worker, Health Information Manager, Director of Dietary and Nurses Managers. The study will continue as directed by the Quality Assurance Committee.	7/20/13

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F 441	Continued From page 8 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain fans in a sanitary manner for two (#8, #99) of thirty-nine residents reviewed. The findings included: Observation on July 1, 2013, at 2:00 p.m., in the room of resident #8 revealed the resident was on the bed with a box fan in operation directed at the resident. Further observation revealed the fan guard and blades had a heavy accumulation of debris. Interview on July 1, 2013, at 2:00 p.m., with Certified Nurse Aide #3 and Licensed Practical Nurse #3, confirmed the fan guard and blades were heavy with debris and blowing in the direction of the resident. Observation on July 1, 2013, at 2:37 p.m., in the room of resident #99 revealed the resident on the bed, with a nasal cannula in place, and a box fan	F 441		

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F 441	Continued From page 9 in operation directed at the resident. Further observation revealed the fan guard and blades had a heavy accumulation of debris. Interview in the resident's room, on July 1, 2013, at 2:42 p.m., with Housekeeper #1, confirmed the fan had debris on the guard and blades and was directed at the resident in the bed. Interview on July 1, 2013, at 2:45 p.m., with Licensed Practical Nurse #4 confirmed the fan grate and blades were dirty and the fan was directed at the resident.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that a emergency bathroom light was functional in one of four common shower rooms. The findings included: Observation and interview with Maintenance employee #1 on July 2, 2013, at 4:36 p.m., in the 2 east shower room, confirmed the bathroom emergency call light was non functional.	F 463	F463 Overseen by the administrator, on 7/2/2013, the resident call in the shower room on 2 East was repaired. Overseen by Administrator on 7/2/2013, all shower room call lights were confirmed to be In working order. Overseen by the Administrator, in-service teaching began for the plant operation staff and all licensed nursing and CNA's to be vigilant to the operation of call lights and to report to maintenance any malfunctioning equipment. Beginning 7/8/2013, a quality assurance study will be overseen by the Director of Maintenance and DON in which 10 random patient call lights will be monitored and inspected for proper operation monthly for 3 months. The DON will monitor compliance of this study, address results as indicated and report to the center's Quality Assurance committee which consists of the Administrator, Director of Nursing, Medical Director, Social Worker, Health Information Manager, Director of Dietary and Nurses Managers. The study will continue as directed by the Quality Assurance Committee.	7/20/13